Health Home Quality Improvement Workgroup - 5/11/2022

Participants

Pamela Lester IME	**Heidi Weaver IME**	**LeAnn Moskowitz IME**
Tami Lichtenberg IME	**David Klinkenborg AGP**	**Sara Hackbart AGP**
Tori Reicherts ITC	Bill Ocker ITC	Flora Schmidt IBHA
Susan Seehase IACP	**Kristi Oliver Children's Coalition**	Paula Motsinger IME
Stacy Nelson Waubonsie	**Amy May Waubonsie**	**Geri Derner YSS**
Jen Cross Orchard Place	Kim Keleher Plains	**Andrea Lietz Plains**
Melissa Ahrens CSA	**Christina Smith CSA**	**Faith Houseman Hillcrest**
Ashley Deason Tanager	**Stephanie Millard First Resources**	**Kristine Karminski Abbe**
Shawna Kalous Plains	**Rich Whitaker Vera French**	**Jamie Nowlin Vera French**
Crystal Hall Tanager	**Brooke Johnson Abbe**	Mike Hines Tanager
Karen Hyatt DHS	Ericka Carpenter Vera French	Kelsey Poulsen Tanager
Krystal Arleaux Orchard Place		

Notes

Last meeting Notes:

- No questions/concerns from group.

Reviewed topics discussed during last Meeting

- Any changes or questions from the group?
    - No response

Draft Workgroup Report:

- The most up to date version was not sent out. This will get sent out with the slides and minutes from this meeting for review.
- In red are items we still need to work through
- In black are items what the group would like to see
- This is really your workgroup report, so your recommendations are what will be presented to Iowa Medicaid leadership
- Executive summary = why and what we want to accomplish
    - High level bullet point list of recommendations

- Items from our last meeting have been added and some items moved around.
    - Take some time to look through this and let Pam know if you see something that needs to be updated or change
- Kristine Karminski - April 16 is the last version of the document received. The most up to date version was not sent out.
- Pam will send out an updated document with today's notes

Overview of the Timeline

- Updated the timeline to go through the end of July.

Payment Methodologies: (Slides 11-15)

- Pam will be on an internal and an external (MCO) Claims and Benefits meeting this month to discuss the 99490. Hope to determine alternate code for the 99490.
- Kristine Karminski - with the discussion around the 99490 change - need to make sure that we are thinking about it in a broader sense and include the other states the MCOs serve. Will there be any impacts to other states?
    - Christina Smith - agree, talked to my team about the 99490, when we bring on a new MCO, seems to be a struggle. Talked with bidding MCOs about this issue so they can be prepared. Feel that there is a ripple effect from other states. The change will help but not fix everything. Regarding billing - what does the state want? Don't want to recommend something that doesn't meet the intention.
- Pam - met about the informational codes with LeAnn and she felt strongly about including the HH services that are provided. When looking at your documentation the HH service on claim doesn't always match the service documentation.
- Christina Smith - we have a lot of moving parts. Challenges with EHR, must do manually, which is a burden. We are looking at getting a new EHR and will address this with them, but it will be at a cost to integrate this. Not an easy fix. What is the cost benefit ratio to it, time, and effort vs cost?
    - Pam - should the workgroup report include those burdens?
    - Kristine Karminski - agree with Christina - our system can attach a primary service; we pay someone to add on the codes each month. Is a burden. If it needs to stay in place, it would be good to know why. Don't think there are other programs that have this level of detail. Balancing cost benefit.
        - Pam- make a great point- how many states require this on the claim
- Kristine Karminski - need to only attest that we provided at least 1 HH service. Is there a middle ground (wiggle room)?
    - Geri Derner - can only bill once per month. If we have 6 contacts only one activity is attached to the billing note sent to the state.
    - Christina Smith - one of the things that our role is to think through is what is all required and what is most required. What is the cost benefit of all these things? Need to determine what is the most important. Not paying for administrative things. Program not sustainable with all the things required. What are some alternatives to including the additional HH services rendered?

- Pam - We are looking at changing our claim report that includes MCO claims that capture those informational codes, but not all services are being captured.
- Richard Whitaker - shifting the work to the billing department, where they are understaffed and over worked doesn't solve the problem. Other states have state reporting (usually monthly), this could replace this. The change the MCOs made regarding the modifier is impacting billing work. Don't have room for that in our staffing model. Having it separate could be better.
    - Pam - what modifier is causing that?
        - Richard Whitaker - to get it on the claims, we had to make adjustments. Does require rework of our other claims (outpatient claims).
        - Jamie Nowlin - if IHH claims are on the same day as other claims - must append modifiers. Having issues with this. When we denied because of same day services, we do the modifier, we are still getting denied. Believe it is the HP modifier.
        - Richard Whitaker - MCOs don' like to see multiple claims on the same day. When the date of service matches another service, the MCOs deny because of a duplicate service.
- Pam - with this group we need to determine a recommendation for this. Need a 99490 and a modifier for each of the tiers. With a tier structure, need the modifier to tell us what that tier is.
    - Sara Hackbart - issue with outpatient service and HH service, these are CMS coding guidelines, not necessary MCO guidelines.
    - Geri Derner- If there is way to have a therapy claim and IHH claim that would be great.
    - Kristine Karminski adding a modifier creates work for the billing folks
    - Geri Derner- our system has set up triggers so that if services are rendered on the same date we receive an alert, but if therapist does their note first, they don't get the same alert.
    - Pam - comes down to the 99490. Agree, we want to make sure we look at other states.
    - Pam - are you swapping one burden for another if you ran a report rather than attached the HH service to the 1500 claim?
        - Christina Smith - running a report would be better
            - Others from group agree
            - Kristine Karminski- agree cautiously - need to know what the expectations on the report would be.
                - Christina Smith - Agrees with Kristine
            - Faith Housman- Also would want clarification as to the frequency of the reporting
    - Kristine Karminski - what makes this program so special? The difference of the level of detail, how is this helping the IHH be successful and how it is helping the member. Hard to embrace when not understanding the why.
- Richard Whitaker - stay focused on outcomes. Counting the services - this is not yet a pop health model (no downside risk). If we could get outcomes reporting,

that is really what we want (great outcomes) and held accountable, that is where the roads lead. Don't want to be accountable for more services.

- LeAnn - appreciate you feedback. The reason we are where we are today is due to the reporting requirements in response to the 2018 OIG audit and corrective action plan the state was required to develop. One of the directions from CMS is documenting all services provided. That is what CMS said is lacking. That is why we introduced the informational codes. Appreciate finding alternative ways to show this.
- Andrea Lietz - agree with what everyone says. If needing to do a report, need to discuss further, could be a good possible solution
- Richard Whitaker - it is easier if you report on a client one time per month. If can figure out that would be good, main principle of management.
- Christina Smith - for Iowa what portion of the administrative costs were calculated? Not known Iowa to include administrative rates. Biggest question. We are running at 13% but need more than that. Feel like it's not built into rate. Looks like it's just staff.
    - Pam- budget neutrality is built into it. Pam will do some follow up on this.
        - Christina Smith - If we increase, does it take from somewhere else?
        - Pam - when I am talking about that, not able to speculate on what we can to do to move budget neutrality
- Pam - summary - we want to focus on PMPM model
    - 99490 is the culprit - what code would result in the least number of denials. What code will work the best?
    - Service codes - what do we do with this information, and do we create the outcomes we want?
    - Do we want a report instead or to report HH services on the claim?

Other state models (slide 16)

- Pam - for the CCHHs, based on a scoring tool, the higher the score the higher the risk of utilization and higher the payment.
- Pam - Want to discuss the tiering or are there other things you have seen in other states you would like to see?
    - Richard Whitaker - don't like the Minnesota model, very complicated. 12 different categories. Like the South Dakota model, like the fact there are incentives for rural areas, rewards on clinic outcome measures, how they calculate their PMPM. It seems like a straightforward, comprehensive way to pay for IHH. The Michigan model looks like it is a super expensive model.
- Pam- does the PMPM model makes sense? Other states look at the staff, caseloads. Other states don't require you follow those caseloads, Some of those things you can still make recommendations for.
    - Christina Smith - feel strongly about the PMPM model. Getting paid a lot less than case management. Love the IHH model, have case management on steroids, just not paying for it. We used to get a PMPM for case management but got paid a lot more. Admin costs for us are running about 13% and wonder what the admin cost are within the PMPM.

        - Pam - maybe include what TCM is paid and get a solution on around this.
    - Melissa Ahrens- agree with PMPM model, is a lot better way to go.
    - Jamie Nowlin - also like the PMPM model- we are struggling with high needs clients because there are no providers in the area so a lot more work on that end.
    - Melissa Ahrens agrees
    - Richard Whitaker - we have lost of a lot of Hab providers.
        - Faith Housman - Shortage of providers for adult and children and for the providers that we still have they are unable to take on more clients due to staffing issues
        - Christina Smith - Also all providers do not have staff, so they are downsizing, so IHHs are bottlenecked.
- Pam - is the tiering system what is needed? Is there a way to simplify a risk based tiering model?
    - Richard Whitaker - seen some tools out there that do a good job with level of care stratification. Just 2 tiers may be oversimplified, having more than 3 tiers may be too much. High, med, low makes sense. Thera are some tools out there. Some places use the DLA 20 (somewhat of a stratifying tool for level of care)
        - Andrea Lietz - use DLA 20. Helps us with determining LOC. Assume there is a cost associated with the DLA20.
        - Jamie Nowlin- Like the idea high, med, low
        - Faith Housman - For Andrea - are you doing it on a quarterly basis or what is the frequency in which you do it?
        - Andrea Lietz - every 3 months. Focuses on the last 30 days. Care coordinators are doing them. Therapist does them as well.
        - Melissa Ahrens - I would be concerned about adding any additional paperwork at this time, however.
- Pam- what do you all use for risk stratification?
    - Kristine Karminski - look at ED and inpatient utilization
    - Melissa Ahrens - have own tool - would like to use the LOCUS once that started. Have been doing LOCUS in Polk regions.
    - Jamie Nowlin - developed own, looks at ED, homelessness, etc.…
    - Geri Derner- created a matrix to establish a high, med, low
    - Faith Housman- We created our own which looks at mental health, physical health, social determinants, etc. We do use the DLA-20 but have had difficulty with staff follow through as it was yet again more paperwork
    - Krystal Arleaux -Orchard Place-risk assessment summary which uses the PQH9 and CRAFFT assessments along with other data.
    - Richard Whitaker - We have our own in-house functional assessment but would like to migrate to DLA-20. Can the DLA-20 replace the LOCUS? Looking for ways to do more with less.
    - Stephanie Millard - I used the DLA-20 for a few years and liked it. DLA-20 train the trainer is only specific to organization trained at so wasn't able to implement here without going through training again. Still looking into this.

Currently use an internal risk strat that looks at records, utilization, gaps in care, historical info, etc.
    - Crystal Hall - we use risk strat, will find out more
- Pam- if we used the same risk stratification tool, will it help to determine where are high risk populations are?
    - Jamie Nowlin- not a terrible idea, getting higher risk folks from outside the area because of their homeless services.
    - Faith Housman - I think if we were to change up our tiers within the PMPM model then we would need to have a standardized risk stratification tool.
    - Geri Derner - if we have a risk stratification tool that is working don't want to dump for another. Look first to see if our own is sufficient. If meets the requirements we can continue to use it or if it doesn't update to ensure it meet the requirements.
    - Jamie Nowlin - no issue with standardized one, not a fan of tracking just ED and inpatient
    - Christina Smith -I agree with Faith, and I do think that it would be interesting information. However as someone not actually doing the work- I hesitate to agree- knowing teaching people a new tool is added stress and change
    - Melissa Ahrens- Agree--the social determinants are extremely important. Risk associated behaviors with transition age individuals in particular
    - Andrea Lietz - If there a way to use the tool but could crosswalk. e.g., DLA crosswalks with LOCUS
- Pam- what are the next steps?
    - You agree with the model but maybe update tiering system to reflect high, medium, and low
    - TCM vs. HH rate
    - 3 tier system instead of 4
    - Is there the ability to create a crosswalk so own tool meets? Or use a standardized tool instead?
    - Jamie Nowlin - I really like the idea of PMPM be dispersed for the high, medium, and low
    - Crystal Hall - Agrees, good idea
    - Kristine Karminski - this is the most impactful - Can this be formulated at the director's meeting, or a meeting be more inclusive?
        - Pam- yes, we can discuss during director's meeting
            - Group agrees
    - Geri Derner- what is the gut feeling as far as what is the prospect of rate changes? Are changes coming soon? Will it depend on the outcomes of this workgroup?
        - Pam - we will take your recommendations around the PMPM to leadership prior to submitting the workgroup report. To make the changes would have to do a SPA revision.

Member Qualifications: (slides 18 & 19)

- How does CMH and Hab fit into this? Do we call them out and keep as is?

    - Kristine Karminski- SPA be focused on the general aspect of IHH services and some of the other things tied to the IAC. Under Hab, someone can be eligible for hab but not meet the member qualifications in the SPA.
- How does the Lead Entity Support Provider Enrollment Activities (Is this process improvement vs SPA update?) Pam- is this more around process improvement rather than SPA changes?
    - Kristine Karminski - process improvement. Fairly general in SPA now.
    - Richard Whitaker - could the lead entity provide lists to the HHs of members that are not engaged but potentially eligible for services?
        - Pam- right now if the MCO identifies specific members they send to the HH for review, feedback given is some members do not qualify. If you get that list and several don't qualify is that creating more of a burden? Did receive lists in phases 1, 2, and 3.
        - Christina Smith - Wondering if getting less in that category from a prevention standpoint
        - Tori Reicherts - medical management team does offer that if member has a qualifying dx and function impairment will refer them over. Issue with lists is, they are a HIPAA compliance issue.
    - Kristine Karminski – Do the MCOs health risk screener as an identifier
        - Tori Reicherts - yes, we use a health risk screener to determine potential need for a referral to Integrated Health Home. We reach out to the member, share information about the Health Home and ask if they would like a referral.
        - Kristine Karminski - would like to hear more on risk screener. Maybe use it in different ways for lower risk folks
        - Tori Reicherts- that is what our teams are doing.
        - Pam- would it be helpful to share with you on the process and where there can be efficiencies?
            - Christina Smith - this good, trying to figure out how to offset the referrals for members in crisis. One idea was to work with MCO partners
            - Jamie Nowlin - We always pass to crisis team first.
    - Pam- will list this under process improvement

<u>Next Steps</u>:

- We will be discussing the following at our next meeting, please be ready to provide your feedback:
    - Follow-up information for PMPM
    - Member qualifications
    - Need to determine what is process improvement and what our recommendations are for SPA changes
- Pam will send the workgroup report as it is now